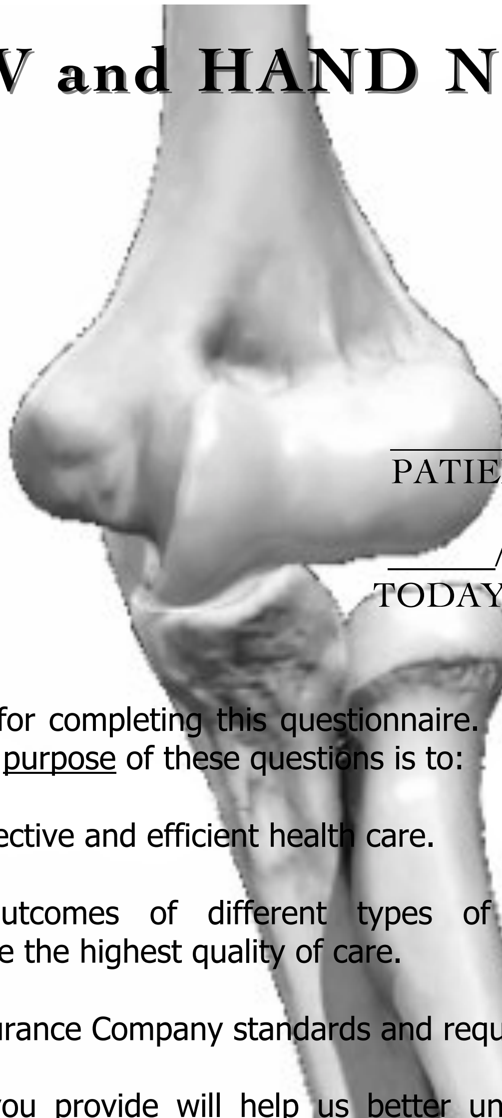
MATTHYS ORTHOPAEDIC CENTER



ELBOW and HAND NEW PATIENT FORM

____
PATIENTS NAME

_____/_____/_____
TODAY'S DATE

Thank you in advance for completing this questionnaire. This should take approximately 40 minutes to fill out. The purpose of these questions is to:

1. provide more effective and efficient health care.
2. evaluate the outcomes of different types of treatment and therefore allow doctors to provide the highest quality of care.
3. Comply with Insurance Company standards and requirements.

The information that you provide will help us better understand your general health and specific problems related to the conditions of the bone and muscle.

This is a confidential document.

HOW DID YOU HEAR ABOUT Matthys Orthopaedic Center (M.O.C.)?

- ☐ Newspaper
- ☐ Internet
- ☐ Billboard
- ☐ Phone Book/Yellow pages
- ☐ Mailer
- ☐ Another patient
- ☐ I am already a patient of Dr. Matthys'
- ☐ Another Doctor referred me
- ☐ Other:__________________

NAME OF REFERRING DOCTOR	**City and State of Referring Doctor**
NAME OF FAMILY DOCTOR (if different)	**City and State of Family Doctor**

TODAY'S DATE

☐☐ - ☐☐ - ☐☐

☐M ☐F

AGE ☐☐☐

CURRENT EMPLOYMENT STATUS:

- ☐ Full time, secretarial or administrative type work
- ☐ Full time, with minimal lifting/bending and climbing/walking (eg. Truck driver)
- ☐ Full time, with frequent lifting/bending and climbing/walking (eg. Carpenter)
- ☐ I am on modified duty because of today's problem
- ☐ I am on modified duty because of another unrelated problem.
- ☐ Part- Time
- ☐ Student
- ☐ Retired
- ☐ Unemployed
- ☐ Disabled. Explain cause/reason for disability:

JOB TITLE/OCCUPATION:

EMPLOYER:

WHICH ELBOW or HAND IS BOTHERING YOU?

☐ RIGHT ☐ LEFT ☐ BOTH

I AM:

- ☐ RIGHT Hand Dominant
- ☐ LEFT Hand Dominant
- ☐ use both hands equally

HOW LONG HAVE YOU HAD THESE SYMPTOMS?

- ☐ No current symptoms
- ☐ Less than one week
- ☐ Less than 2 months
- ☐ 2- 6 months
- ☐ 6 months to 1 year.
- ☐ 1 year to 3 years
- ☐ 3 years to 5 years
- ☐ greater than 5 years

IF THERE WAS AN ACCIDENT, PLEASE DESCRIBE HOW IT HAPPENED?

____

____

____

DATE of accident or onset of symptoms:

☐☐ - ☐☐ - ☐☐

PLEASE DESCRIBE YOUR CURRENT PROBLEM?

- ☐ This is a **NEW** injury. I have never had problems with my ELBOW or HAND
- ☐ The symptoms **started slowly** and have progressively worsened.
- ☐ I have had this problem for **many years** and the symptoms have stayed the same
- ☐ This is a **re-injury**. Treatment was received in the past and was better until a new injury occurred.

IS THIS IS WORKMAN'S COMP CASE?

☐ yes ☐ no

HAVE YOU SEEN ANOTHER ORTHOPAEDIC DR. FOR YOUR SYMPTOMS?

☐ yes ☐ no

HAVE YOU CONSULTED A LAWYER ABOUT TODAY'S PROLEM?

☐ yes ☐ no

COMPARED TO 2 MONTHS AGO, HOW WOULD YOU RATE YOUR SYMPTOMS?

- ☐ No current symptoms
- ☐ Much Better
- ☐ Little Better
- ☐ the same
- ☐ Little Worse
- ☐ Much Worse

WHAT MAKES YOUR PAIN <u>WORSE</u>?

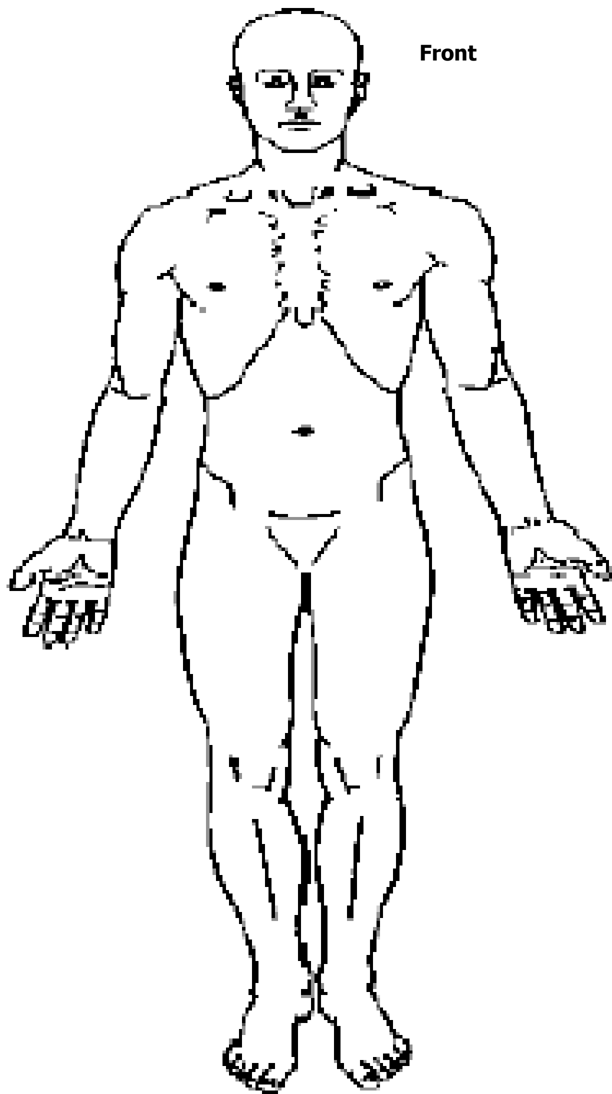
- ☐ OVERHEAD WORK
- ☐ SPORTS or RECREATIONAL ACTIVITY
- ☐ SLEEPING
- ☐ Other:______________________

WHAT MAKES YOUR PAIN <u>BETTER</u>?

- ☐ MY PAIN IS LESS WHEN I AM ACTIVE
- ☐ MY PAIN IS LESS IF I REST IT
- ☐ MEDICATION
- ☐ THERAPY
- ☐ INJECTIONS
- ☐ Other:______________________

PLEASE MARK THE *BODY DIAGRAM* BELOW WITH AN "X" FOR SHARP PAIN or an "O" FOR NUMBNESS. MARK ALL AREAS THAT APPLY.

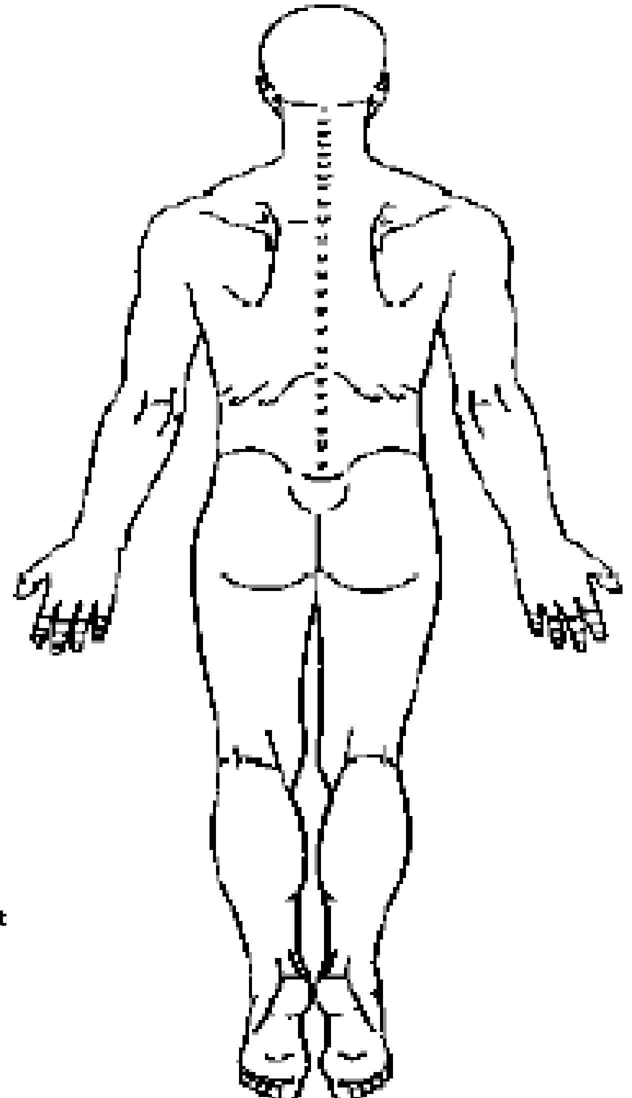
Front



Right

Left

Back



WHERE IS THE PAIN? PLEASE CHECK (X) ALL THOSE THAT APPY:

- ☐ NECK
- ☐ TOP OF SHOULDER
- ☐ BACK OF SHOULDER
- ☐ SIDE OF SHOULDER
- ☐ UPPER-ARM
- ☐ PAIN THAT STARTS IN THE NECK AND GOES DOWN TO MY FINGERTIPS
- ☐ ELBOW
- ☐ FOREARM
- ☐ WRIST
- ☐ FINGERS

HOW INTENSE IS YOUR PAIN? IF '0' IS NO PAIN AND '10' IS SEVERE PAIN? Please circle a number that applies.

Scale	
0	NONE
1	
2	MILD
3	
4	TROUBLESOME UNCOMFORTABLE
5	
6	DISTRESSING
7	
8	HORRIBLE, INTENSE PAIN
9	
10	UNBEARABLE, EXCRUTIATING

MY SYMPTOMS ARE:	**MY PAIN IS BEST DESCIBED AS:**
☐ CONSTANT AND OCCURS EVERY DAY	☐ SHARP SHOOTING
☐ ARE INTERMITTENT BUT OCCUR EVERY DAY	☐ DULL and ACHY
☐ <u>NOT</u> PRESENT EVERY DAY	☐ BURNING

MY PAIN DURING THE DAY IS :

- ☐ None or I Ignore it.
- ☐ Slight, but no compromise in my activity. Pain improves with activity.
- ☐ MILD or OCCASIONAL pain. Pain is present more with unusual ACTIVITY, but disappears with rest.
- ☐ MODERATE PAIN, <u>some</u> limitations is usual activity at work or with exercise. Need to take medications regularly
- ☐ MODERATE pain during and after activities. NO pain at Rest (INTERMITTENT). <u>Many</u> limitations.
- ☐ MODERATE pain during and after activities. <u>Many</u> limitations.
- ☐ SEVERE pain, present constantly and intense. Many limitations. Nearly bed-ridden.

INSTRUCTIONS for the DASH Score: This questionnaire asks about your symptoms as well as you ability to perform certain activities. Please answer *every question,* based on your condition in the **last week**. If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate. It doesn't matter which hand or arm you use to perform the activity; please answer based on you ability regardless of how you perform the task.

Please rate your ability to do the following activities in the last week.	**No difficulty**	**Mild difficulty**	**Moderate difficulty**	**Severe difficulty**	**Unable**
1. Open a tight or new jar	☐	☐	☐	☐	☐
2. Write	☐	☐	☐	☐	☐
3. Turn a key	☐	☐	☐	☐	☐
4. Prepare a meal	☐	☐	☐	☐	☐
5. Push open a heavy door	☐	☐	☐	☐	☐
6. Place an object on a shelf above your head	☐	☐	☐	☐	☐
7. Do heavy household chores (e.g. wash walls, wash floors)	☐	☐	☐	☐	☐
8. Garden or do yard work	☐	☐	☐	☐	☐
9. Make a bed	☐	☐	☐	☐	☐
10. Carry a shopping bag or briefcase	☐	☐	☐	☐	☐
11. Carry a heavy object (over 10 lbs)	☐	☐	☐	☐	☐
12. Change a light bulb overhead	☐	☐	☐	☐	☐
13. Wash or blow dry your hair	☐	☐	☐	☐	☐
14. Wash your back	☐	☐	☐	☐	☐
15. Put on a pullover sweater	☐	☐	☐	☐	☐
16. Use a knife to cut food	☐	☐	☐	☐	☐
17. Recreational activities which require little effort (eg card playing, knitting, etc)	☐	☐	☐	☐	☐
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (eg golf, hammering, tennis, etc)	☐	☐	☐	☐	☐
19. Recreational activities in which you move your arm freely (eg playing frisbee, badminton, etc)	☐	☐	☐	☐	☐
20. Manage transportation needs (getting from one place to another)	☐	☐	☐	☐	☐
21. Sexual activities	☐	☐	☐	☐	☐

	Not at all	Slightly	Moderately	Quite a bit	Extremely
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?					

	Not limited at all	Slightly limited	Moderately limited	Very limited	Unable
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?					

Please rate the severity of the following symptoms in the last week	None	Mild	Moderate	Severe	Extreme
24. Arm, shoulder or hand pain					
25. Arm, shoulder or hand pain when you performed any specific activity					
26. Tingling (pins and needles) in your arm, shoulder or hand					
27. Weakness in your arm, shoulder or hand					
28. Stiffness in your arm, shoulder or hand					

	No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty	So much difficulty I can't sleep
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?					

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem					

MAYO ELBOW SCORE

Please answer the following questions.

Section 1 - Pain Intensity
None
Mild
Moderate
Severe

Section 2 - Motion
Arc of motion greater than 100 degrees
Arc of motion between 50 and 100 degrees
Arc of motion less than 50 degrees

Section 3 - Stability

- ☐ Stable
- ☐ Moderate instability
- ☐ Grossly Unstable

Section 4 - Function (Tick as many as able)

- ☐ Can comb hair
- ☐ Can eat
- ☐ Can perform hygiene
- ☐ Can don shirt
- ☐ Can don shoe

PLEASE CHECK (X) ANY OF THE *ANTI-INFLAMMATORY* MEDICATIONS THAT YOU HAVE TRIED AND CIRCLE THOSE THAT YOU ARE CURRENTY TAKING.

- ☐ Motrin/Ibuprofen/*Advil*
- ☐ Celebrex
- ☐ Vioxx
- ☐ Valdecoxib/*Bextra*
- ☐ Aspirin
- ☐ Tylenol/Acetaminophen
- ☐ Indomethicin/*Indocin*
- ☐ Naproxen/Naprosyn/*Aleve*
- ☐ Piroxicam/*Feldene*
- ☐ Nabumetone/*Relafen*
- ☐ Tramadol/*Ultram*
- ☐ Etodolac/*Lodine*
- ☐ Diclofenac/*Voltaren*
- ☐ Oxaprozin/*Daypro*
- ☐ Mobic
- ☐ Glucosamine Chondroitin Sulfate
- ☐ Prednisone
- ☐ Other:________________________

PLEASE CHECK (X) ANY OF THE *PAIN RELIEVING* AND *MUSCLE RELAXING* MEDICATIONS THAT YOU HAVE TRIED AND CIRCLE THOSE THAT YOU ARE CURRENTY TAKING.

- ☐ Codeine / Tylenol #3
- ☐ Vicodin/Hydrocodone
- ☐ Lortab
- ☐ Darvocet
- ☐ Tylox
- ☐ Percocet
- ☐ Percodan
- ☐ Fioricet
- ☐ Methadone
- ☐ Dilaudid
- ☐ Demerol
- ☐ Roxicet
- ☐ Soma
- ☐ Flexaril
- ☐ Valium
- ☐ Skelaxin
- ☐ Robaxin
- ☐ Zanaflex
- ☐ Other:_____________

PLEASE CHECK (X) ANY OF THE FOLLOWING SIDE EFFECTS YOU MAY HAVE EXPERIENCED WHILE TAKING THE ABOVE MEDICATIONS

- ☐ NONE
- ☐ NAUSEA
- ☐ HEARTBURN or UPSET STOMACH
- ☐ ULCERS
- ☐ STOOLS CHANGE COLOR (DARK)
- ☐ DIARRHEA
- ☐ VOMITING
- ☐ OTHER:_____________________

DURING THE PAST 4 WEEKS HOW OFTEN HAVE YOU TAKEN MEDICATION FOR EACH JOINT?

	RIGHT ELBOW	LEFT ELBOW
ALWAYS (max dosage)	1	1
OFTEN (every day, but NOT maximum dosage)	2	2
SOMETIMES (3-5 times per week)	3	3
OCCASIONALLY(1-2 times per week)	4	4
NEVER	5	5

ARE THE MEDICATIONS THAT YOU ARE TAKING FOR YOUR PAIN RELIEVING YOUR SYMPTOMS?

☐ **YES** ☐ **NO**

HAVE YOU EVER BEEN TREATED AT A *PAIN CLINIC*?

☐ **YES** ☐ **NO**

PREVIOUS TREAMENT FOR YOUR RIGHT ELBOW or HAND PAIN. PLEASE CHECK (X) those that apply.

TREATMENT	RIGHT ELBOW….. with relief					
CORTISONE injection	☐YES	☐NO	☐YES	☐NO	Last injection Date:____________	How many Treatments? ____________
PHYSICAL THERAPY	☐YES	☐NO	☐YES	☐NO		How many Treatments? ____________
ACCUPUNCTURE	☐YES	☐NO	☐YES	☐NO		
CHIROPRACTIC CARE	☐YES	☐NO	☐YES	☐NO		

PREVIOUS TREAMENT FOR YOUR LEFT ELBOW or HAND. PLEASE CHECK (X) those that apply.

TREATMENT	LEFT ELBOW….. with relief					
CORTISONE injection	☐YES	☐NO	☐YES	☐NO	Last injection Date:____________	How many Treatments? ____________
PHYSICAL THERAPY	☐YES	☐NO	☐YES	☐NO		How many Treatments? ____________
ACCUPUNCTURE	☐YES	☐NO	☐YES	☐NO		
CHIROPRACTIC CARE	☐YES	☐NO	☐YES	☐NO		

PREVIOUS SURGERY TO THE SHOULDER(S), ELBOW(S) and/or HAND(S):

DATE OF SURGERY	WHICH SIDE?	SURGEON/Hospital	PROCEDURE	COMPLICATIONS
	R / L / BOTH			
	R / L / BOTH			
	R / L / BOTH			
	R / L / BOTH			

Which ONE of the following includes the highest level of formal schooling that you have had?

- ☐ No Formal Schooling
- ☐ Elementary School
- ☐ High School
- ☐ Some College
- ☐ College Degree
- ☐ Graduate School

Are You married?

- ☐ Yes, married
- ☐ No, Never married
- ☐ No, divorced or separated
- ☐ No, widowed

Which ONE of the following best describes your living current living arrangement?

- ☐ I live alone in a house or apartment
- ☐ I live with my family in a house or apartment
- ☐ Assisted Living Center: *Location* ________________________________
- ☐ Nursing Home: *Location* ________________________________
- ☐ other (please Describe) ________________________________

SOCIAL HABITS

DO YOU USE TOBACCO PRODUCTS? **YES NO.**

☐ CHEWING TOBACCO ☐ CIGARS ☐ CIGARETTES ☐ PIPE

If ***yes***, how many packs/cigars a day?________. About what year did you start?_________.

HAVE YOU EVER USED TOBACCO? **YES NO.**

If ***yes***, how many years?________. About what year did you quit?_________.

DO YOU DRINK ALCOHOL SOCIALLY? **YES NO.**

If ***yes***, how many drinks per week?________.

DO YOU FEEL YOU DRINK ALCOHOL IN EXCESS? **YES NO.**

DO YOU USE RECREATIONAL DRUGS? **YES NO.**

HAVE YOU EVER USED RECREATIONAL DRUGS? **YES NO.**

DO YOU HAVE ANY **ALLERGIES** TO MEDICATIONS? **YES NO.**

☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Betadine

☐ OTHER __________________

DO YOU HAVE AN **ALLERGY** TO LATEX? **YES NO.**

DO YOU HAVE ANY **ALLERGIES** TO FOOD? **YES NO.**

MEDICAL PROBLEMS (see next page): check all that apply, Now or in the Past

☐ **I HAVE NOT HAD ANY MEDICAL PROBLEMS OR PREVIOUS ILLNESSES**

General	NOW	PAST	**Respiratory**	NOW	PAST	**GU (men)**	NOW	PAST
Fever			Shortness of breath (SOB)			Testicular pain or masses		
Chills			Asthma			**GU (women)**		
Drenching night sweats			COPD/Emphysema			Irregular menses/amenorrhea		
Itching			T.B.			Dysmenorrhea		
Fatigue			Positive PPD or prior BCG			Hot flashes		
Change in weight			Pneumonia or bronchitis			Pregnancy loss		
Change in appetite			Wheezing			**Extremities-muscles-joints**		
HIV/AIDS			Chronic Cough			Osteoarthritis		
Alcoholism			Hemoptysis			Rheumatoid Arthritis		
Fibromyalgia			Pulmonary embolus			Gout		
Skin			Sleep apnea			Morning stiffness		
Jaundice			Any abnormal chest X-ray in past			Joint injuries		
Skin cancer (what kind)			**Cardiovascular**			Raynaud's		
Psoriasis			High Blood pressure			Morning stiffness		
Eczema			Chest pain or Angina			Back pain		
Head			Heart attack			Neck pain		
Headache/migraines			Murmur			**Neurologic**		
Other head pain			arrhythmia			Seizures or epilepsy		
Trauma			Atrial Fibrillation			Stroke		
Skull fracture			Normal Stress Test			Dizziness or vertigo		
Ears			Abnormal Stress Test			Tremor		
Decreased hearing			Dizziness			Involuntary movements		
Tinnitus or ringing			Syncope or near-syncope			Balance problems		
Discharge			Loss of consciousness			Numbness or tingling in Feet		
Infection			Edema or swelling in both feet			Numbness or tingling in Hands		
Pain			Blood clots			Memory concerns		
Eyes			**Abdominal**			**Endocrine**		
Pain			Pain			Thyroid problems		
Infection			Nausea/vomiting			Heat or cold intolerance		
Glaucoma			Change in bowel habits			Diabetes Type I (Insulin Requiring		
Dry eyes			Diarrhea or constipation			Diabetes Type II (oral medications)		
Macular degeneration			Bright red blood per rectum			Diabetes-borderline		
blindness			History of polyps			Excessive thirst		
Nose			Colon cancer			Frequent Fractures		
Frequent bleeding			Pancreatitis			Loss of height		
Sinus Problems			Gall bladder disease			**Hematologic**		
Changes in smell			Gallstones			Anemia		
Mouth/Throat			Irritable bowel syndrome (IBS)			Sickle Cell Disease		
Tongue problems			Inflammatory bowel disease (IBD)			Swollen lymph nodes		
Change in taste			Hepatitis			Blood diseases		
Mouth lesions or ulcers			Hernias			Leukemia/lymphoma		
Dentures			**GU**			Bleeding problems		
Dry mouth			Frequency			Blood clots		
Bleeding(mouth/gums)			Burning			Past use of blood thinners		
Gum disease			Blood in the urine			**Psychiatric**		
Problems swallowing			Kidney stones			Depressive symptoms (e.g. feeling down)		
Neck			Urinary tract infection (UTI)			Anxious		
Thyroid problems			Cystitis			Phobias		
Lumps, masses, nodules			Incontinence			OCD behaviors		
Breasts			Bladder cancer			ADD/ADHD behaviors		
Masses			Prostate cancer			Panic attacks		
Discharge			Uterus/cervical cancer			Hallucinations (visual/auditory)		
Pain						Suicidal/homicidal thoughts		
Cancer						Bipolar Disorder		

SF36 Health Survey

INSTRUCTIONS: This set of questions asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question please give the best answer you can.

1. In general, would you say your health is: (Please tick **one** box.)

- Excellent ☐
- Very Good ☐
- Good ☐
- Fair ☐
- Poor ☐

2. Compared to one year ago, how would you rate your health in general now? (Please tick **one** box.)

- Much better than one year ago ☐
- Somewhat better now than one year ago ☐
- About the same as one year ago ☐
- Somewhat worse now than one year ago ☐
- Much worse now than one year ago ☐

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? **(Please circle one number on each line.)**

	Activities	Yes, Limited A Lot	Yes, Limited A Little	Not Limited At All
3(a)	**Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
3(b)	**Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
3(c)	Lifting or carrying groceries	1	2	3
3(d)	Climbing **several** flights of stairs	1	2	3
3(e)	Climbing **one** flight of stairs	1	2	3
3(f)	Bending, kneeling, or stooping	1	2	3
3(g)	Waling **more than a mile**	1	2	3
3(h)	Walking **several blocks**	1	2	3
3(i)	Walking **one block**	1	2	3
3(j)	Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	(Please circle one number on each line.)	Yes	No
4(a)	Cut down on the **amount of time** you spent on work or other activities	1	2
4(b)	Accomplished less than you would like	1	2
4(c)	Were **limited** in the **kind** of work or other activities	1	2
4(d)	Had **difficulty** performing the work or other activities (for example, it took extra effort)	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (e.g. feeling depressed or anxious)?

	(Please circle one number on each line.)	Yes	No
5(a)	Cut down on the **amount of time** you spent on work or other activities	1	2
5(b)	Accomplished less than you would like	1	2
5(c)	Didn't do work or other activities as **carefully** as usual	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups? (Please tick **one** box.)

- Not at all ☐
- Slightly ☐
- Moderately ☐
- Quite a bit ☐
- Extremely ☐

7. How much physical pain have you had during the past 4 weeks? (Please tick **one** box.)

- None ☐
- Very mild ☐
- Mild ☐
- Moderate ☐
- Severe ☐
- Very Severe ☐

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Please tick **one** box.)

- Not at all ☐
- A little bit ☐
- Moderately ☐
- Quite a bit ☐
- Extremely ☐

9. These questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that is closest to the way you have been feeling for each item.

	(Please circle one number on each line.)	**All of the Time**	**Most of the Time**	**A Good Bit of the Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**
9(a)	Did you feel full of life?	1	2	3	4	5	6
9(b)	Have you been a very nervous person?	1	2	3	4	5	6
9(c)	Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
9(d)	Have you felt calm and peaceful?	1	2	3	4	5	6
9(e)	Did you have a lot of energy?	1	2	3	4	5	6
9(f)	Have you felt downhearted and blue?	1	2	3	4	5	6
9(g)	Did you feel worn out?	1	2	3	4	5	6
9(h)	Have you been a happy person?	1	2	3	4	5	6
9(i)	Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives etc.) (Please tick **one** box.)

- All of the time ☐
- Most of the time ☐
- Some of the time ☐
- A little of the time ☐
- None of the time ☐

11. How TRUE or FALSE is each of the following statements for you?

	(Please circle one number on each line.)	**Definitely True**	**Mostly True**	**Don't Know**	**Mostly False**	**Definitely False**
11(a)	I seem to get sick a little easier than other people	1	2	3	4	5
11(b)	I am as healthy as anybody I know	1	2	3	4	5
11(c)	I expect my health to get worse	1	2	3	4	5
11(d)	My health is excellent	1	2	3	4	5

Thank You!

MEDICATIONS: Please list all medications you are taking including over-the-counter medications.

☐ I DO <u>NOT</u> TAKE ANY MEDICATION

MEDICATION	DOSEAGE	HOW OFTEN	MEDICATION	DOSEAGE	HOW OFTEN
1.			5.		
2.			6.		
3.			7.		
4.			8.		

PERSONAL SURGICAL HISTORY

☐ **I HAVE <u>NEVER</u> HAD SURGERY**

PLEASE CHECK ALL THAT APPLY AND GIVE APPROXIMATE **YEAR** SURGERY WAS PERFORMED.

ABDOMINAL SURGERY:
- ☐ APPENDIX
- ☐ GALL BLADDER REMOVAL
- ☐ HERNIA REPAIR
- ☐ AORTIC ANEURYSM (AAA)
- ☐ GASTRIC BYPASS
- ☐ COLON RESECTION or COLOSTOMY
- ☐ NISSEN (reflux surgery)
- ☐ REMOVAL OF SPLEEN
- ☐ ORGAN TRANSPLANT

CARDIOVASCULAR SURGERY:
- ☐ ANGIOPLASTY or STENT
- ☐ ARTERY BYPASS IN LEGS
- ☐ OPEN HEART SURGERY and BYPASS
- ☐ VEIN STRIPPING
- ☐ OPEN HEART SURGERY and VALVE SURGERY
- ☐ CAROTID (neck) ARTERY SURGERY

MUSCULOSKELETAL:
- ☐ CARPAL TUNNEL SURGERY
- ☐ ARTHROSCOPY SURGERY
- ☐ FRACTURE REPAIR
- ☐ CERVICAL/NECK SPINE SURGERY
- ☐ JOINT RELACEMENT SURGERY
- ☐ LUMBAR/LOWER BACK SURGERY

OTHER:
- ☐ THYROID REMOVAL
- ☐ TONSILLECTOMY
- ☐ CATARACT SURGERY
- ☐ PLASTIC SURGERY
- ☐ BRAIN SURGERY
- ☐ SINUS SURGERY
- ☐ LASIX EYE SURGERY

FEMALES ONLY:
- ☐ HYSTERECTOMY (uterus)
- ☐ OOPHORECTOMY (ovaries)
- ☐ TUBAL LIGATION
- ☐ BLADDER SUSPENSION SURGERY
- ☐ C-SECTION
- ☐ BREAST BIOSPY or MASTECTOMY

MALES ONLY:
- ☐ PROSTATE SURGERY
- ☐ BREAST BIOSPY or MASTECTOMY
- ☐ VASECTOMY
- ☐ TESTICULAR SURGERY

OTHER SURGERY NOT LISTED ABOVE:

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FAMILY HISTORY : DOES YOUR GRANDPARENTS, MOTHER, FATHER OR BROTHERS/ SISTERS OR CHILDREN HAVE ANY ON THE FOLLOWING MEDICAL PROBLEMS (LIVING OR DECEASED)?

Disease or Problem	yes	no	Relation
CANCER			
ANESTHESIA PROBLEMS			
TUBERCULOSIS			
Kidney problems			

Disease or Problem	yes	no	Relation
HEART DISEASE			
BLEEDING PROBLEMS			
CLOTTING PROBLEMS			
JOINT REPLACEMENT			

SIGN HERE

Signature of person filling out this form

OFFICE USE ONLY:

	RIGHT elbow	LEFT elbow
Active/Passive FLEX	/	/
Act./Passive extension	/	/
Act./Passive pronation	/	/
Act./Passive supination	/	/

- Demographics
- Location of symptoms
- Mechanism of injury
- Date of Injury
- Quality of symptoms
- Onset and resolution of symptoms.
- Frequency of episodes.
- Limitations in activity
- Severity of symptoms (pain scale)
- Sports participation
- Alleviating factors
- Exacerbating factors
- Associated symptoms (numbness, tingling,LBP, locking,catching,instability)
- Assistive devices
- Previous treatment
- Previous workup (MRI, bone scan, etc)

Doctor/PA's signature